

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31553**

FILED OCT 4 - 1943

Registration District No. **128**

Primary Registration District No. **5467**

Registrar's No.

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **BRIGHTON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **R.F.D. #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
In this community **69 YR 11 MO. 4 DAYS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **WILLIAM HARVEY KING**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **OCT 27 1873**
(Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **4** If less than one day hr. min.

9. Birthplace **GREENE CO. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARMING**

12. Name **JOHN KING**

13. Birthplace **MO.**
(City, town, or county) (State or foreign country)

14. Maiden name **MYRA TILLER**

15. Birthplace **MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Iida King**

(b) Address **Brighton**

17. (a) **Burial** (b) Date thereof **OCT 3-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Robbison Prairie**

18. (a) Signature of funeral director **J. W. King**

(b) Address **Springfield MO**

19. (a) **10-1-1943** (b) **W. H. Korman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE 039**
(c) City or town **Brighton**
(If outside city or town limits, write "RURAL")
(d) Street No. **R#** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **1** at
year **1943** hour **6** minute **00 A.** M.

21. I hereby certify that I attended the deceased from **9-1** 19**42** to **9-30** 19**43**
that I last saw him alive on **9-30** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular heart disease**
Due to **Coronary artery disease**

Due to **116**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**
Of autopsy **none**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury

23. Signature **J. F. Freeman** (M. D. or other)
Address **Springfield MO** Date signed **10/1/43**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Ray A. Levine

Licensed Embalmer No. *1763*

P. O. Address *Springfield Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.